ORMAN PHYSICIAN COACHING

SCRIPTING YOUR LEAST FAVORITE CONVERSATIONS

1ST EDITION

WHAT'S YOUR PAIN POINT?

When I pose the question, "Which patient conversations do you find the most challenging in the Emergency Department?" what thoughts emerge? This query is undoubtedly personal, and the responses can vary significantly. Such discussions might include delivering unfavorable news, navigating uncivil exchanges, or saying no to patient requests. In this codex, we'll focus on the last one, delivering a 'no'.

What is it about these conversations that put them in the least favorite category?

Why don't we like telling people no?

- We are natural pleasures, we don't want to anger the patient and have that impact satisfaction scores
- It's exhausting getting pushback all day long and saying 'yes', just to avoid a hassle, is so seductive. Saying 'no' can sap your energy
- A no takes a lot longer than a yes.

Why do I have to explain myself... *who's the doctor here*?!?!

Why is it important to have a script?

A script helps you save energy and also gets the conversation right every time. When you are tired, it's going to be hard to think of what you want to say on the spot, especially when it's something that potentially irritates you.

If you are having the same conversation multiple times a day or even a few times a week, that is ripe for a framework.

What follows are a few examples of what scripting can look like. There are myriad ways to approach this and I'd love to hear your ideas.

SCRIPT 1: ANTIBIOTICS FOR VIRAL URI

I've yet to meet anyone in front-line healthcare who hasn't had a patient antibiotic request to treat URI symptoms (including sinusitis of a very short duration).

Patients want to feel better and often have the belief that the path to that is an antibiotic prescription. It's hard to blame them - this is the prevailing wisdom of much of the lay public. The conversation goes something like this...

"I've had a week of coughing, a runny nose, sinus congestion. My doctor always writes me a Z- pack, can I get one of those?"

Cough, Cough. A tissue is presented with a **big green loogie**

"Check out my sputum. It was yellow yesterday! Clearly, I need antibiotics."

What's the common refrain from us?

"You have a cold, antibiotics won't make it better, in fact, all they'll do is harm." You lay out the harms and science, diarrhea, toxic megacolon, and print out the most recent Choosing Wisely. You deliver your **logic.**

Some patients will, in fact, respond to a logical answer. When that happens, it's like drinking a glass of cold water on a hot summer day.

But that is not the norm.

The norm is to have pushback or even irritation. Diarrhea and all the other horrible consequences of unnecessary antibiotics rarely register. While you are explaining your reasoning and hard-earned knowledge, the patient's thought bubble probably looks something like this:

"Will they give me my Z-pack or not? Just say YES and let's be done with this."

We think we are giving a logic answer.

What they're hearing is No. NO. No, you cannot have what you want. Being told no and not getting what you want elicits an emotional response.

They are experiencing emotion. Logic does not work well at solving emotional challenges.

Two frameworks

Here are two frameworks to address this situation. In each, there's a basic assumption that you respect them and their interests. Do not dismiss or invalidate. Think of it this way: If you hadn't done all that medical training, you would probably have the same ask that they do.

FRAMEWORK 1: RESPOND IN THIS ORDER: YES, NO, YES.

Yes.

Understand why you're saying no - what really matters to you? This is what you're saying YES to. In this case, it could be to avoid harm and satisfy yourself that you're doing the right thing. Maybe it's something like, "I am saying yes to embracing the Hippocratic oath and practicing medicine in accordance with those values."

This sets the foundation of your purpose.

No.
You are saying no to the issue, not the person. This is a mindset shift from judgment to discernment. It's much easier to say no to the question rather than the person.

Avoid 'You' statements in favor of 'The' statements.
For example, "You are incorrect in thinking that an antibiotic will fix you," vs, "The idea that antibiotics effectively treat this kind of infection is common, and to the best of our knowledge, it's just not the case."

Yes.
Have a viable alternative.

DIGGING DEEPER

Yes
The internal yes.
I want to embody *do no harm* and practice evidence-based medicine.

The external yes
"Good news, it doesn't look like a bacterial infection or anything serious right now."

No.
"You've told me that you've gotten better in the past when you've taken a Z-pack (validation). This is a common experience for many patients (social proof) - feeling better after starting antibiotics when they have a cold or recent sinusitis. In my experience, here's what I see happen with that: those who do and don't take the antibiotics end up having the same duration of illness and those who get antibiotics get a whole lot more diarrhea.

Yes.
"It's no fun having a cold, I know I hate it (compassion) what I've found works well for this situation is X plan..."

EXPECT RESISTANCE AND PUSHBACK!

Did you expect to get off that easily? Tsk, tsk. Pushback is most likely knocking at the door.

Pushback Response Option 1
Stay firm with your boundaries, but guide the patient to acceptance of the situation with kindness and compassion.

“So you aren’t going to write me for antibiotics???”

“I hear you! And I know it can be frustrating (empathy and compassion). It’s a common question I get every day (social proof) and to the best of our knowledge, antibiotics do more harm than good with what you've got going on.”

Pushback Response Option 2
I learned this from infectious disease maestro Greg Moran.

“Yeah, you probably did feel better. I think you probably would have felt better even without that Z-Pak last time. Now, maybe the situation was different than what your doctor saw last time, but I know for what you're here with now, antibiotics are not going to help.”

FRAMEWORK 2: UNEARTH THEIR SPECIAL KNOWLEDGE

This approach comes from the field of hostage negotiation. It’s a mindset shift from, “I have special knowledge to tell the patient (that viruses don’t need antibiotics)” to, “THEY have special knowledge I need to understand.”

The special knowledge in this case is **what brought them to see you**. It’s **what’s behind why** they want antibiotics.

How do you know that you understand their special knowledge? When the patient says, “That’s exactly right.” Try to get there before the physical exam.

The special knowledge script

You: So you’ve got chills, congestion, cough, and have had 2 negative COVID swabs in the last 3 days. What’s on your mind?
Patient: I can’t be sick, I think I need an antibiotic
You: Tell me more.
Patient: My husband has Parkinson’s, and we are going to Tanzania in 2 weeks, I can’t miss this trip! It’s a life goal of ours and we will never be able to do it again.
You: So you’re worried if you don’t get the antibiotics now, you’ll miss the trip?
Patient: Well, I’m not missing it no matter what, but I can’t be sick for it. I’ll be with a ton of people, many of whom are older, and I can’t be contagious. I need to be better.
You: So you’re thinking if you get an antibiotic now it’ll make sure you aren’t contagious for the trip?
Patient: That’s exactly right.
You Alright, let’s do your exam!

The patient feels heard and can address their actual fear, anxiety, and reason for coming. In this case, “You won’t be contagious in 2 weeks. You might still be coughing, but an antibiotic won’t change that, and you could get something like diarrhea from it that would throw everything out of whack.”

SCRIPT 2: ASYMPTOMATIC HYPERTENSION

Once you’ve ruled out life threats and end-organ dysfunction, what’s left is a number. A scary number to many.

Sometimes the patient is scared that they're going to have a stroke, heart attack, or that the number itself is so high that it's passed the threshold from tolerable to frightening.

Another confounding factor can be expectations of a big workup/big deal/true emergency set by someone else prior to you seeing the patient.

Pro-tip. Don't throw whoever sent in the patient under the bus. It's a bad look and serves no one.

Inside you might be thinking, "Why are you wasting my time?" and possibly, "Am I going to be hobbled by the message the patient may have received before seeing me, that this blood pressure is impending doom?

What might the patient be thinking? It may be along the lines of, "Is something horrible about to happen to me because of this high blood pressure?"

The payoff comes in validation

FRAMEWORK 1: YES, NO, YES.

Internal Yes
I'm going to evaluate for life threats as needed and, if there are none, not harm this patient by acutely lowering their blood pressure. Slow and steady wins the race.

External Yes (I'm glad you're here)
I'm so glad you're here so we can talk about this because it's normal to see that high number and be afraid.

No (nothing needs to be done emergently)
The good news is that I don't see any sign that this elevated blood pressure number is causing a problem right now. What we look for when blood

pressure is elevated, as yours is right now, is damage to sensitive organs like the brain, heart, eyes, and kidneys. I don't see any sign of that right now (based on exam, testing, or however you go about it).

Yes (the plan from here to make sure you're taken care of)
"The problem with a blood pressure number like this comes later on which is why we need to pay attention to it over the long haul. The big question is this- is what's happening right now a weird blip that won't come back or a sign that your blood pressure needs closer attention, here's what I'd suggest we do..."

And then a clear plan - whether that's starting them on meds, changing meds, or just having them check their BP at home and taking the results to the PCP.

PUSHBACK

"Aren't you going to do something about my blood pressure right now?"

"Great question (validation). I know it can be scary and confusing given that you've gotten some mixed messages today (empathy and compassion). It's a common question I get every day (social proof) and the one thing we do know about high blood pressure is that lowering it too much or too fast is the real danger. We used to lower asymptomatic high blood pressure in the emergency department which ended up causing strokes, so we try to stay away from that these days."

FRAMEWORK 2: THEY HAVE SPECIAL KNOWLEDGE

You: I see your blood pressure has been sitting at 190/100 for the last week and was even higher in the clinic. Tell me your biggest concern with this.
Patient: That's a high number and I don't want to have a stroke!
You: Tell me more.

Patient: My father had high blood pressure and went to the ER for it. They told him it was no big deal and he had a stroke the next day.
You: So you're worried that you could wind up in the same situation as your father?
Patient: Not only that, my BP has never been this high. I'm not even on medication for this.
You: So you're thinking that there's something new and serious going on and don't want to end up having an even worse problem because of it?
Patient: That's exactly right.
You Alright, let's do your exam!

SCRIPT 3: NON-EMERGENT MRI FOR BACK PAIN AND NO RED FLAGS

FRAMEWORK 1: YES. NO. YES.

Internal Yes
I want to be a good steward of limited resources and avoid potential financial harm to the patient.

External Yes
"I realize you don't feel well or are worried about X, I want you to know that I want you to feel better too. I appreciate that you think you need this test."

No
"I know you were expecting a (MRI/etc) today. Unfortunately, we're only able to obtain MRIs directly from the ED for a very limited set of dangerous, emergency conditions like an abscess in the spinal canal, or a herniated disk pressing on the spinal cord. You may very well end up needing an MRI to get more information about what's causing your symptoms, but I'm confident we're not dealing with a situation where you need to be rushed emergently to the operating room. As a result, let's work on treating your symptoms. I'm happy to speak with your provider and discuss our findings today so we can

work together to get you the appropriate imaging in a timely fashion outside of the ED."

Yes
Help facilitate follow-up. Make a call, make an appointment. Just saying, “Go back to your PCP,” won't get it done....they sent the patient to you! Where we often fail is we don't give the patient the lifeline to the next step.

FRAMEWORK 2: THEY HAVE SPECIAL KNOWLEDGE

You: So you had a week of back pain shooting down your leg and it’s not getting better. What’s on your mind? (or "What do you think needs to happen today?" "What are you most worried about today?")
Patient: My back hurts and I want to know what’s going on, I want an MRI to figure it out.
You: Tell me more.
Patient: My neighbor had the same thing, got an MRI, and had surgery the same night. I told my doctor about this, and he said go to the ER to get an MRI.
You: So your doctor recommended an MRI through the ER and you’re worried you might need surgery?
Patient: Yes
You: And you're thinking that without an MRI we won’t know what’s going on and things will only get worse?
Patient: That’s exactly right.
You: Alright, let’s do your exam!

PUSHBACK

Ask, “What are you hoping to learn from the test?”
Educate - How to pursue non-emergent testing.
Money - In some cases, insurance won’t pay for an emergent test unless truly indicated, and the patient may have to pay out of pocket. Educating yourself on the validity of this potential pitfall can go a long way.

I hope this guide was useful. If you have questions, ideas, alternate approaches, want to share any thoughts, or set up a coaching discovery call, feel free to reach out. You can contact me through the website **roborman.com**.

Keep on rocking,

Rob Orman, MD
Emergency Physician and ICF Certified Executive Coach

FURTHER READING

- The Power of a Positive No. William Ury.
- Crucial Conversations: Tools for Talking When Stakes are High. K Patterson, et al.
- Never Split the Difference. Chris Voss, Tahl Raz

GRATITUDE

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DISCLAIMER

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